Every decision about me, with me

Adult Safeguarding Learning Level 3

1.5 hours

City and Hackney CCG

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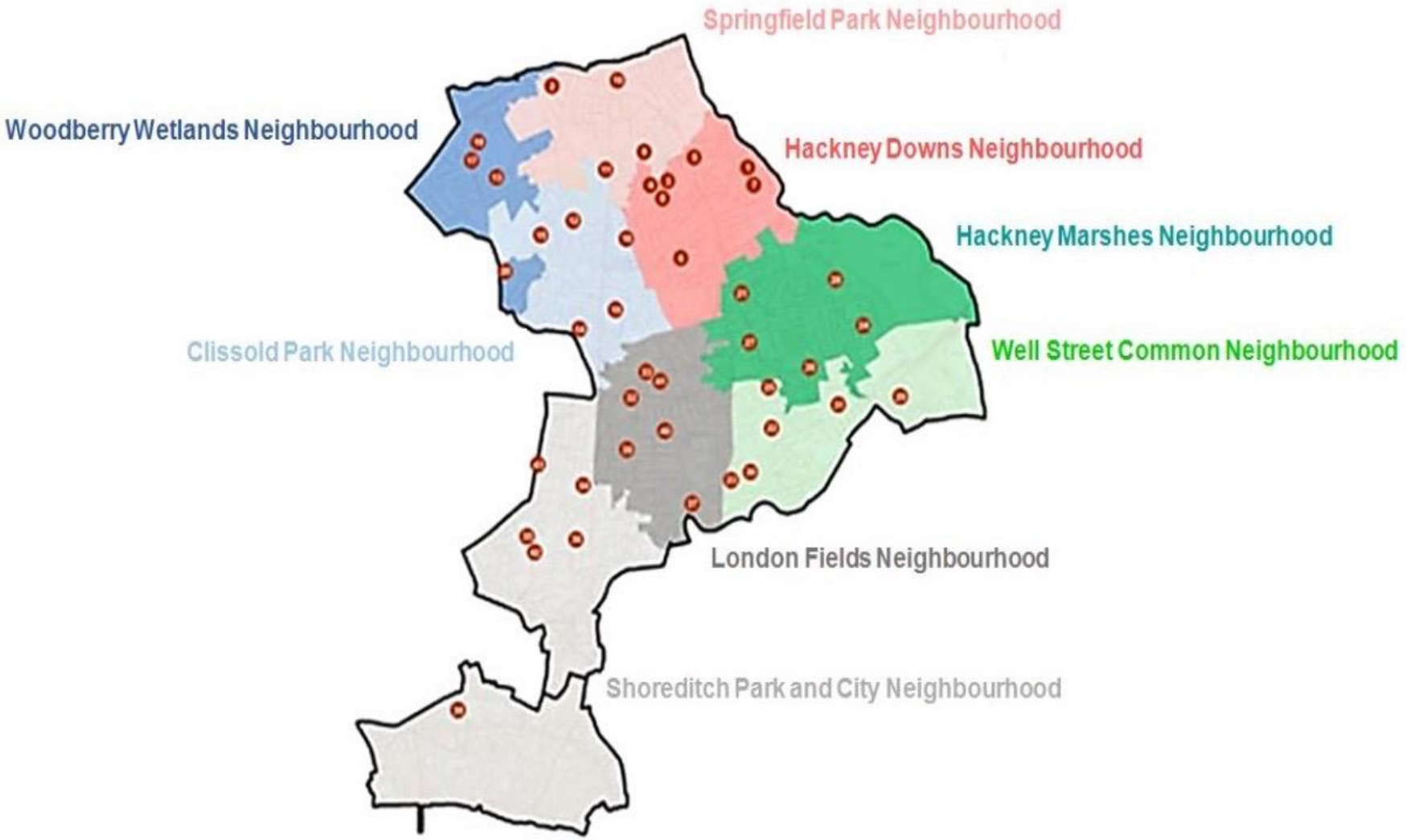
30 October 2019


HELLO
MY NAME IS

City and Hackney Networks/Neighbourhoods
Where do you work?



Adult Safeguarding Learning

Every decision about me, with me

- Level 3 safeguarding Training is mandatory for all clinical staff
- Required 8 hours Adult Safeguarding Training every three years
- This training = 1.5 hours
- Learning outcomes for this session
  - Engaging with uncertainty and ambivalence
  - Developing **responsible curiosity**
  - Escalating concerns
  - Safe and relevant information sharing
  - Making considered judgements about how to act to safeguard an adult at risk
  - Working safely within the Mental Capacity Act
  - Contributing to Safeguarding Adult Reviews (SARs)
  - **Primary Care Networks** for system learning and successful collaborative interagency practice

What is new in Adult Safeguarding Legislation?
What must I do?

- **Modern Slavery** Act 2015
  - Obligation to report

- **Homelessness Reduction** Act 2017
  - Obligation to provide care and treatment
  - Rough Sleeping Support https://hackney.gov.uk/rough-sleeping
  - Safer Surgeries for people without documentation

- **Domestic Violence** Bill 2019 (delayed)
  - NB coercive control

- **FGM/Cutting*** 2019
  - Changes to compulsory reporting: genital piercing not need to report
  - *When Safeguarding becomes stigmatising https://research-information.bristol.ac.uk/files/187177083/Karlsen_et_al_2019_When_Safeguarding_become_Stigmatising_Final_Report.pdf

- **Liberty Protection Safeguards to replace DOLs** 2020
  - Amendment to Mental Capacity Bill which removes people's rights to information/advocacy before their deprivation of liberty is authorised
  - Capacity is still decision specific and best made with professional closest to decision e.g. medication review - GP, housing – social worker

Modern Slavery

HM Government

Victims of modern slavery exist all around us. They are vulnerable people, who in many cases have been forced into work by gang-masters who take control of their finances and freedom.

As a healthcare worker, victims of modern slavery could be patients you encounter everyday.

Any combination of these signs could help you identify a victim:

- **They may be accompanied by their exploiter, who is posing as a translator or relative**
- **They're controlled: they are rarely left alone and cannot speak for themselves**
- **They may have unexplained or untreated injuries**
- **They may have long term malnourishment, low bone density or decaying teeth**
- **They may show signs of mental health issues such as PTSD, trauma or hyper paranoia**
- **They may not be registered with a GP and may lack clarity in explaining their medical history**

If you see or hear something that doesn't feel right or need more information, search the Modern Slavery Helpline. Every report could save a life.

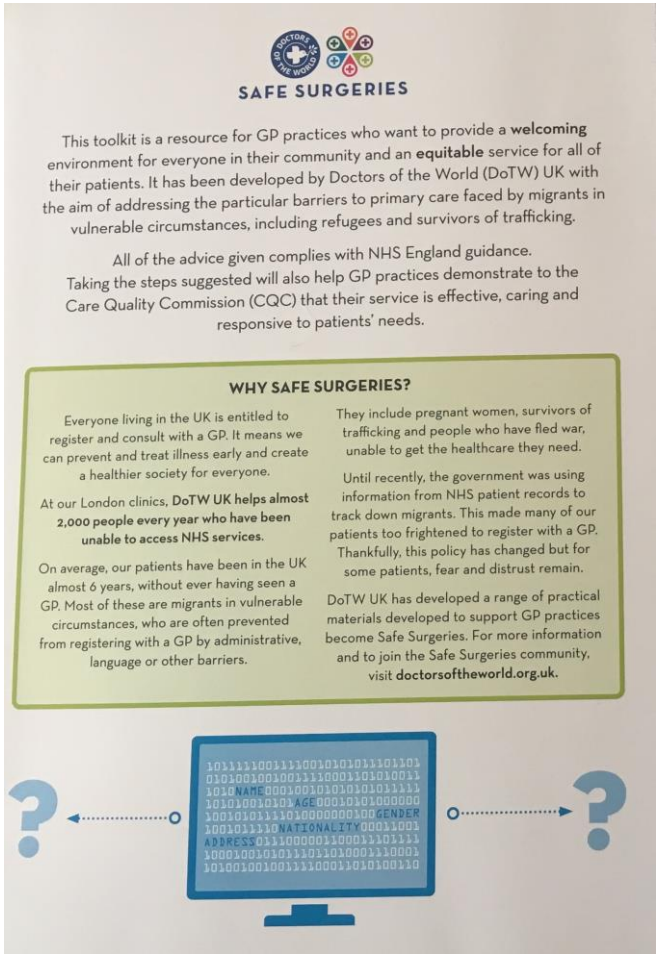
modern slavery helpline

08000 121 700

Spot it. Stop it.

Safe Surgeries

Entitlement to health care for refugees and vulnerable migrants in the UK



SAFE SURGERIES

This toolkit is a resource for GP practices who want to provide a **welcoming** environment for everyone in their community and an **equitable** service for all of their patients. It has been developed by Doctors of the World (DoTW) UK with the aim of addressing the particular barriers to primary care faced by migrants in vulnerable circumstances, including refugees and survivors of trafficking.

All of the advice given complies with NHS England guidance. Taking the steps suggested will also help GP practices demonstrate to the Care Quality Commission (CQC) that their service is effective, caring and responsive to patients' needs.

WHY SAFE SURGERIES?

Everyone living in the UK is entitled to register and consult with a GP. It means we can prevent and treat illness early and create a healthier society for everyone.

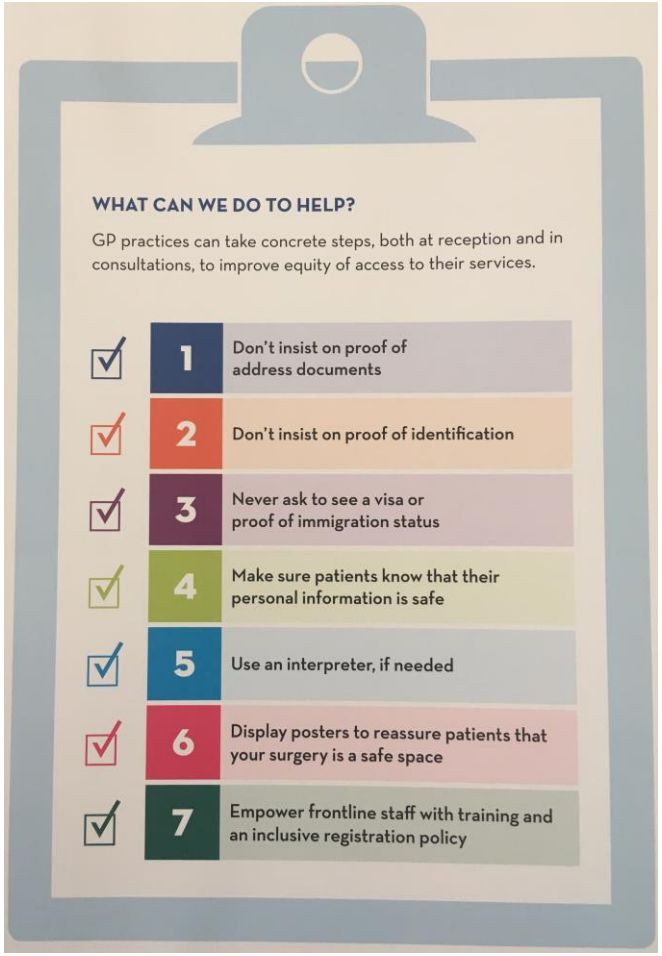
At our London clinics, **DoTW UK helps almost 2,000 people every year who have been unable to access NHS services.**

On average, our patients have been in the UK almost 6 years, without ever having seen a GP. Most of these are migrants in vulnerable circumstances, who are often prevented from registering with a GP by administrative, language or other barriers.

They include pregnant women, survivors of trafficking and people who have fled war, unable to get the healthcare they need.

Until recently, the government was using information from NHS patient records to track down migrants. This made many of our patients too frightened to register with a GP. Thankfully, this policy has changed but for some patients, fear and distrust remain.

DoTW UK has developed a range of practical materials developed to support GP practices become Safe Surgeries. For more information and to join the Safe Surgeries community, visit **doctorsoftheworld.org.uk.**



WHAT CAN WE DO TO HELP?

GP practices can take concrete steps, both at reception and in consultations, to improve equity of access to their services.

1. Don't insist on proof of address documents
2. Don't insist on proof of identification
3. Never ask to see a visa or proof of immigration status
4. Make sure patients know that their personal information is safe
5. Use an interpreter, if needed
6. Display posters to reassure patients that your surgery is a safe space
7. Empower frontline staff with training and an inclusive registration policy

Domestic Violence in City and Hackney

National Data

- Research indicates that victims experience on average 35 assaults before ending a relationship https://www.refuge.org.uk/our-work/forms-of-violence-and-abuse/domestic-violence/domestic-violence-the-facts/
- The risk of harm to the victim is highest at the point of leaving the relationship and for up to two years afterwards
- An average of two deaths per week are domestic violence related
- Femicide Census – 'overkilling' force used greater than that needed to kill https://www.womensaid.org.uk/what-we-do/campaigning-and-influencing/femicide-census/

Local Data from Hackney Police

- 60/40 split in terms of victims female:male respectively
- Typically 400 offences per month noted by police - July spike most years i.e. 500 offences
- Note also intra-familial e.g. not an intimate relationship but for example between siblings; adult child violence on parent

Scenario 1

Mr and Mrs K, a couple both aged 90+, and both with capacity, are reporting being verbally abused by their son, M who has a gambling addiction. In the latest incident, M became aggressive with Mrs K when she confronted him about his addiction. Mrs K left the house but was grabbed by M and carried back into the house and thrown onto the floor, causing bruising to her jaw and thigh.

Mr and Mrs K have a paid carer who has reported a number of incidents including this one. It is part of a series of escalating incidents over a five year period. Mrs K has been to the practice numerous times to report that she feels anxious and is fearful of her son.

On several occasions, Mrs K has been afraid to remain in her home and has stayed away for short periods, either at a guest house or in short term care. Mrs K has provided information to suggest that M is controlling. He monitors her mail and phone calls, checks her bank statements without permission and checks her purse when she returns from shopping. Mr and Mrs K give M money regularly and have purchased a car for him very recently. M holds Mr K's visa card. Mr and Mrs K have been advised to ask M to leave and to stop giving him money, but they have not taken this advice.

Due to Mrs K's age and frailty, professionals are concerned that another physical attack could prove fatal.

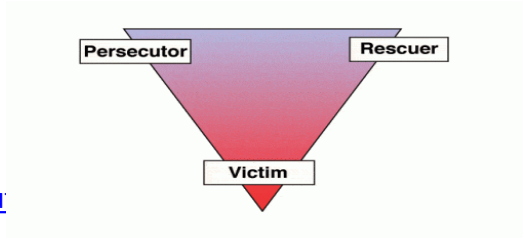
What happened next?

- MARAC Referral- criminal justice system follows up regarding son, multi-agency discussion regarding suitable housing for Mr and Mrs K
- Specialist IDVA support for Mrs and Mr K, safety measures in place at victims home (panic alarm, special schemes, sanctuary referral, tecsos* phone)
- Capacity assessments / dementia screening for both parties- found to have capacity to make decisions.
- Adult Safeguarding Section 47 enquiry, specialist assessment of Mr and Mrs K focussing on their reasons for making apparently repeated 'unwise decisions' and discussion regarding inherent jurisdiction.
- Children's social care referral regarding M – he has children with his ex-partner and maintains regular contact

*https://www.securedbydesign.com/about-us/news/tecsos-uses-technology-to-help-victims-of-domestic-abuse

Domestic Violence – Challenges for the Practitioner

- Supporting sharing of observations at practice meetings – when does 'a hunch' become a concern / risk analysis
- Identifying symptoms such as tiredness, low mood, withdrawal as possible signs
- Linking child and adult case notes?
- Alerts to flag parental vulnerability
  - 'Child not brought' alerts for Children flag up Domestic Violence
  - Underusing of emollients?
  - Other?
- Code Domestic Violence?
- **Stay curious** and retain a positive relationship with a patient who may be struggling to make changes
- Recognising **coercive control**
- **Focus on strengths - How are you keeping yourself safe?**
- Provide a safe listening ear and **avoid rescuing** – failed attempts at being rescued cause the victim to push away from the rescuer https://lindagraham-mft.net/triangle-victim-rescuer-persecutor-get/



Where to refer?

1. **Iris** http://www.irisdomesticviolence.org.uk/iris/about-iris/abou

2. **DAIS** (Hackney Local Authority) - have perpetrator programme that GP's can refer in patients who want help with managing their anger/behaviour https://www.hackney.gov.uk/article/4022/Domestic-Abuse-Intervention-Service

1. **GP MARAC** - Assessment Conference - Health, Housing, Police, Voluntary Sector, Advocate for victim

   Liaison Nurse Jessica Woods Safeguarding Children Team Telephone: 0207 014 7167 Mobile: 07852339430 Generic Email: huh-tr.MARAC@nhs.net Email: Jessica.woods@homerton.nhs.net Secure: jessicawoods@nhs.net Twitter: @HUHSafeguardingMulti Agency Risk

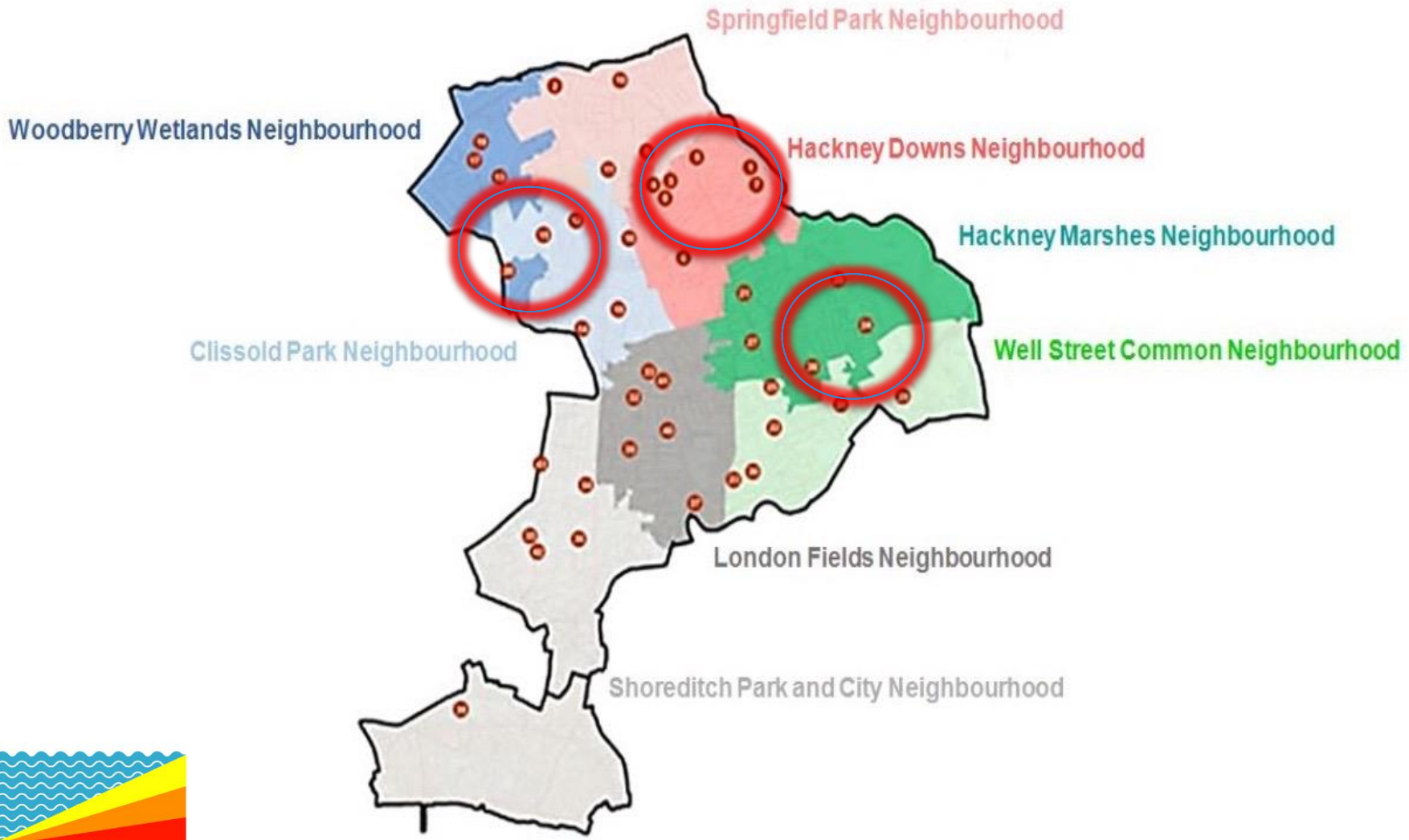
Safeguarding Data City and Hackney

- **CHUSHE Adult Safeguarding Concerns** from 1.1.2018-31.12.2018 - **System at night**
  - 53 cases included with 26/53 (49%) people having both functional transition (frail person) and carer burden (frail community) as their prompt for safeguarding
  - 23/53 (43%) are >70yrs and 15/53 (28%) > 80yrs (onset of multi-morbidity occurs 10–15 years earlier in people living in the most deprived areas compared with the most affluent)
  - Pocket and blanket disadvantage/deprivation in Neighbourhoods/Networks
    - E5 (14 cases)
    - E9 (12 cases)
    - E16 (12 cases)
    - N1 (6 cases)
    - N4 (4 cases)
    - Rest scattered through the borough
- **Mental Capacity Audit** 2018 identified <u>GP learning needs</u>
  - Considering capacity in relation to a new decision
  - Enabling positive risk taking especially **Medication Reviews**

- **Serious Case Review** identified <u>GP learning needs</u>
  - Ability to assess capacity
  - Recognising carer burden
  - Understanding functional trajectories in particular people confined to their chair or bed who have pressure ulcers and recognise risks associated with PEG feeding
  - Handovers within and outside the practice
- **CHSAB Annual Report** 2016/17 - 32 concerns raised (Section 42), of which 22 led to Section 42 Enquiry

  Themes included:
    - Neglect (N=12)
    - Financial (N=6)
    - Physical (N=4)
    - Self neglect (N=3)
    - Domestic (N=2)
    - Multiple (N=5)

WHERE?
City and Hackney at night by postcode



GPs at the Deep End

https://www.gla.ac.uk/researchinstitutes/healthwellbeing/research/generalpractice/deepend/

WHO ELSE?

Caring for the whole system at night

Locum GP who does a home visit at 2am to establish what matters to someone who managed to make a call but who is intermittently confused, confined to their bed, alone at home and living in neglected social housing

How do we look after and sustain kindness in this GP?

- Other people working at night? Bank staff in care homes? 111?
- Cultures of **blame and shame**
- Workforce core needs: Belonging, competency, autonomy https://www.kingsfund.org.uk/blog/2019/03/nhs-crisis-caring

Organisational abuse (C&H Safeguarding Adults at Risk of abuse and harm)

Neglect and poor care practice as a result of the structure, policies, processes and practices within an organisation.

- within an institution or specific care setting such as a hospital or care home
- care provided in one's own home
- range from one off incidents to on-going ill-treatment
- deliberate
- result of ignorance
- lack of training, knowledge or understanding
- if a person is being abused in one way they are also being abused in other ways

Ms F's story Sept 2017

' I am 44 years old and have lived in Hackney all my life. I was diagnosed with Multiple Sclerosis 10 years ago, which has now affected my ability to communicate fluently, and I need support to express my decisions and for every other aspect of my life including being helped to eat and drink. I feel like a spectator in my life starting but nor completing things that are important to me.

I have two carers, who change a lot so I don't know them but who help me four times a day. They are always in a rush to their next client. I live with my son who has cerebral palsy and who has his own live-in carer. My adult daughter has been a carer herself since the age of 7years and she is trying to complete her college course despite her own mental health issues.

*I don't want to be a burden and I am so thankful for all the care I get that I did not want to make a fuss when my mattress started to deflate on **4 September**. My daughter tried to inflate the mattress unsuccessfully and wasn't sure who to contact because the contact details on the mattress had faded.*

*I told the carers that I had been uncomfortable overnight and that I was in pain. Over the next four days my carers cared for me on my deflated mattress. The mattress company came on **8 Sept** and noticed that I had developed a large pressure ulcer and contacted my GP who contacted the district nurse. There must have been some confusion as the district nurse only came on the **10 Sept**. My pressure ulcer was dressed daily until **14 Sept** when I was admitted to hospital as the pressure ulcer had reached my bone and was infected. I was treated in hospital until **30 September**.*

*I was in a **lot of pain** but did not want to make a fuss. It must not happen again. God, no!'*

Appreciative Inquiry Mindset

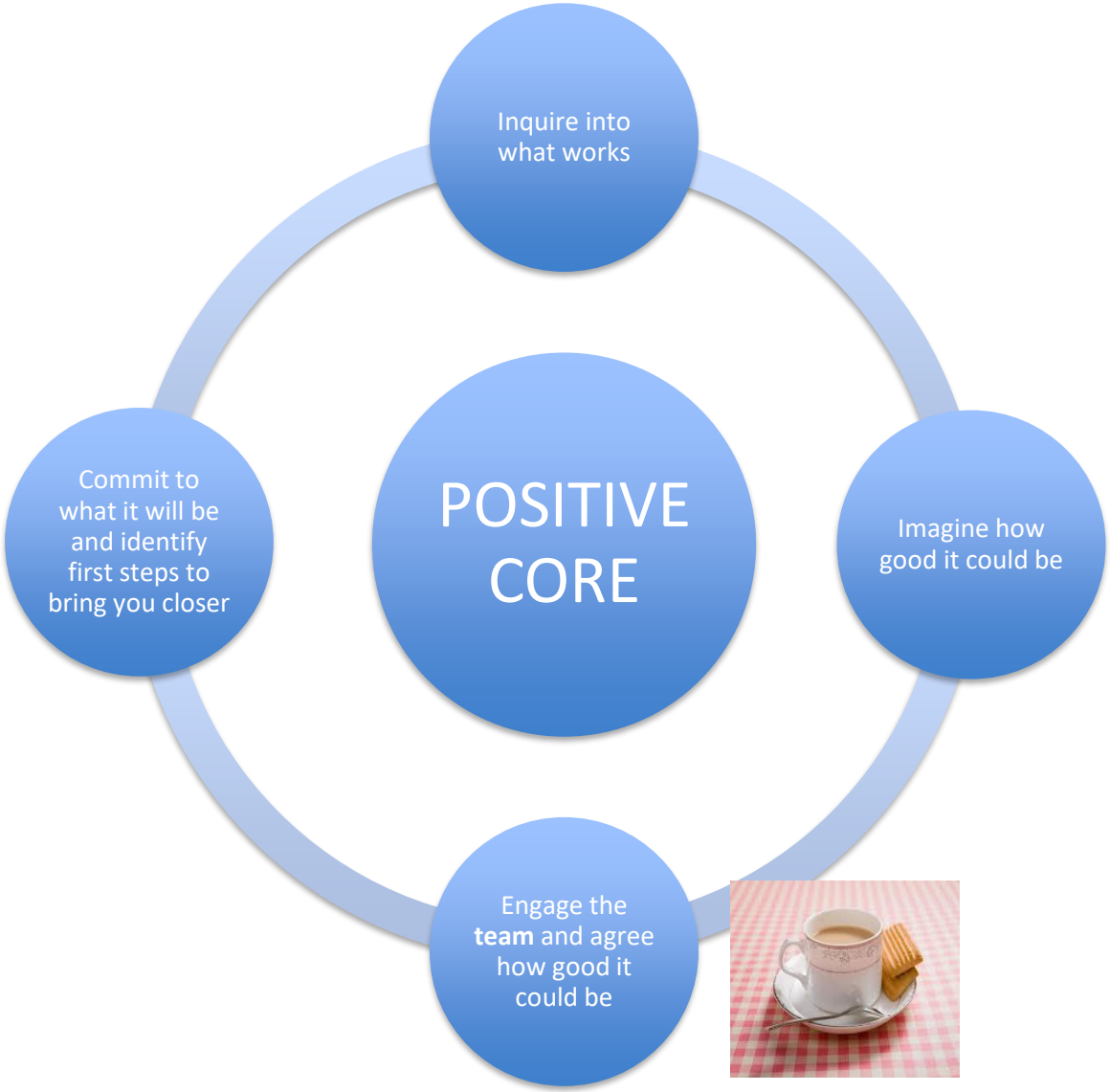
Resourceful (Frail) Person? Strong (Frail) community? Resilient (Frail) System?

What is already working and how can we build on that?

1. **Resourceful Person:**
   How was Ms F and her family empowered in shaping her care?

2. **Strong Community:**
   Who is looking after the carers?

3. **Resilient System:**
   How kind was the system to the people who delivered care to Ms F?



Primary Care Networks and Safeguarding

Opportunities

- Access to colleagues knowledge and experience
- Home visits – access to personal context
- Knowledge of family others registered at the same address
- Centralisation of information from other sectors
- Human Factors focus for safety – relationship based care
- Collaborative problem solving – Safeguarding Leads Action Learning Sets
- Communities of practice for system learning and transformation
- **Transitional Safeguarding** - bridging support from young adult to adulthood to 25y https://www.basw.co.uk/resources/safeguarding-during-adolescence–-relationship-between-contextual-safeguarding-complex
- **Contextual Safeguarding** - Strengthen context - local relationships with practices, schools, voluntary sector https://hackney.gov.uk/contextual-safeguarding
  - Inverse care law - the unworried unwell
  - Areas of high social disadvantage - patients consult more, feel less enabled and their doctors feel more stressed

Primary Care Networks and Safeguarding

Challenges

- Volume of work: lack of personal achievement from burnout and de-personalisation
- System complexity - multiple providers involved, change often
- Blame and shame culture
- Virtual contacts for many may miss other information
- Loss of relational continuity of care for individuals and families i.e. children and parents seen by different GPs
- GP part time working – reliant on well communicated handovers
- Lone working – home-visits
- Difficult to establish relationship with patients due to appointments system
- Over reliance on the medical record - loss of soft intelligence
- Coding variation ‘child cause for concern’, patient held records
- **HANDOVERS**

A home visit - 1

- You are a GP Locum and asked to do a home visit to Mrs S who has had a fall and has shoulder pain
- Referral made by Speech and Language Therapist [SLT]
- You check the notes and you see that Mrs S cannot communicate without the aid of the Speech and Language Therapist [SLT] as she has Motor Neurone Disease
- You have never met this Mrs S before this time
- She has a named GP, that GP is not in and the last four visits have been done by 4 different GPs none of whom are on site
- You are unable to get hold of the SLT before the visit

A home visit - 2

History from Husband Mr S present says pain and bruising left shoulder since fall 4/7 ago, he was upstairs and heard her fall, found her on left side, since fall not been able to use left hand to feed herself. Hadn't noticed bruising until mentioned by SLT

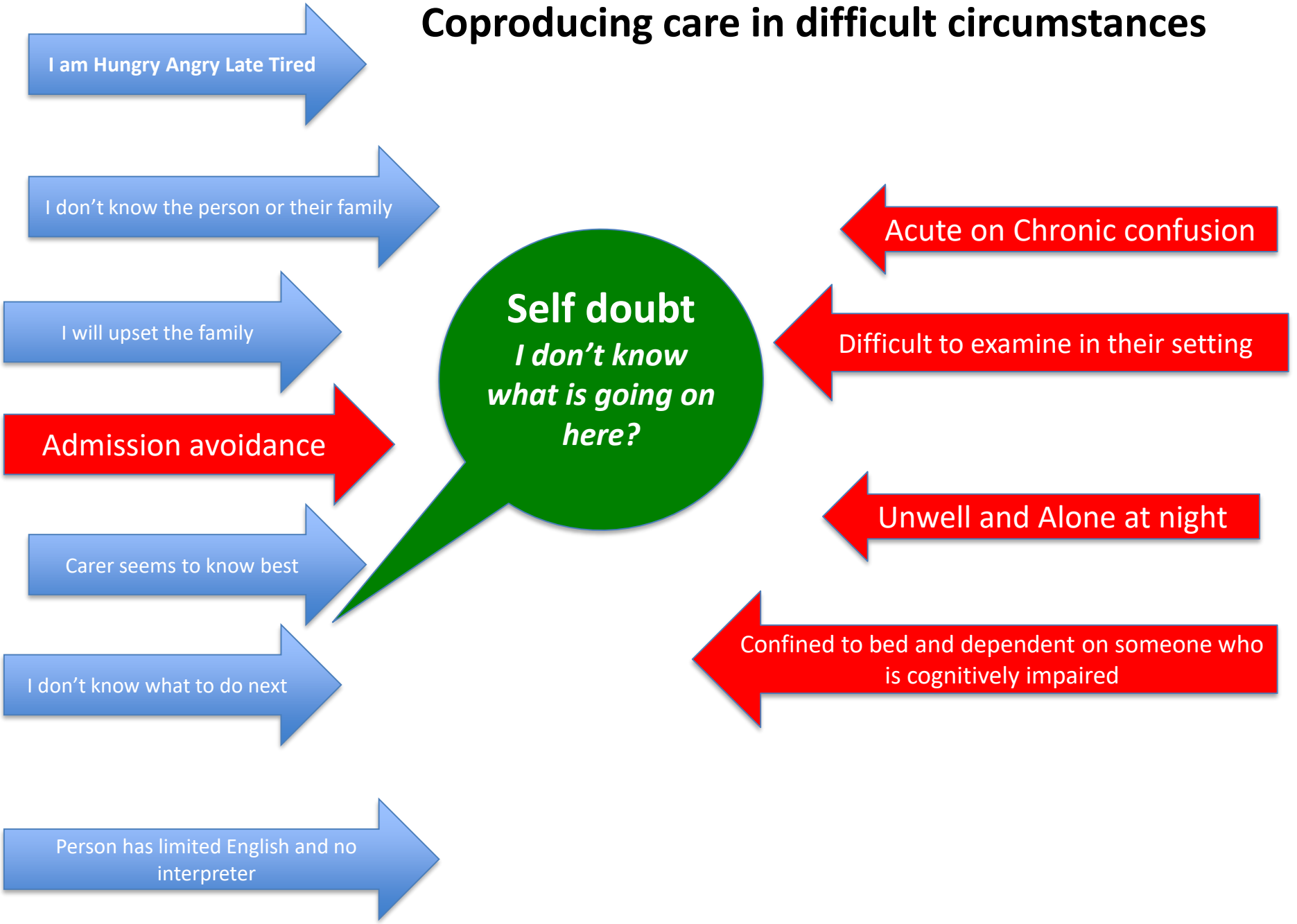
Mrs S is according to her husband

- Cognitively impaired past 4 years, able to communicate wishes with aid of SLT
- Functionally very limited, chair dependent, transitions with aid but sometimes able mobilise occasionally on own
- Lives with him - stair lift in place past few days and recent move from microenvironment on ground floor upstairs now shares room with husband. He is responsible for all her care and care of the house. He tells you, he has had his own recent possible serious diagnosis. Note he is not registered at the same practice as his wife
- On a good day according to her husband she will be more responsive and cries less, enjoys having grandchildren around

Consent through husband to examine Mrs S

You examine her and you note bruising over the left clavicle

Coproducing care in difficult circumstances



A home visit - 3

- Need for x-ray was discussed with husband as uncertainty of diagnosis
- Mr S explained multiple barriers why he was not able to take Mrs S for an x- ray that afternoon
- Locum GP left with plan for analgesia and to review in 48 hours when he would be back at practice as no clear handover plans were in place at the practice
- Locum GP on reflection was unhappy with plan and following morning called and spoke to duty doctor that patient needed to go into A/E for review and not wait
- Duty Doctor said that they didn't know patient or family and best for Locum GP to call Mr S and let him know change of plan
- Locum GP called and encouraged Mr S to take Mrs S to A/E
- X-ray showed fractured clavicle
- Mrs S was admitted as carer burden was recognised
- Mrs S was moved to supported accommodation where she now lives
- Mr S diagnosed with lung cancer and died a few months after this event

Handing over early recognition of vulnerability amongst the ‘frail’

HANDY APPROACH TO CARE
@sparrow_tweets

Subjective – Objective

Frail person?
Frail community?
Frail system?

- **Living well at the End of Life. Adapting Health Care to serious chronic illness in old Age** (RAND 2003)
- **The End of the Disease Era** (Am J Med 2004)
- **Medical care for the final years of life: "When you're 83, it's not going to be 20 years”** (JAMA 2009)
- **Epidemiology of multimorbidity and implications for health care, research, and medical education** (Lancet 2012)

(1) https://howardbarlow.photoshelter.com

What is the Handy Approach to Care?

- Integrated Framework for professionals to formulate care
- Balances narratives of dignity and safety [1]
- Ideal for handovers (tested in Newham Community Health Services)
- Combines all domains of care:
  - Mental
  - Physical
  - Social
  - Personal
- **Safe: Three Safeguarding Alerts (mental, physical, social)**
- Easy to learn and to remember - mapped on the hand (tested Tower Hamlets CHS)
- Quick to use
- Person-centred: Captures baseline through an impression of the lived life of person receiving care
- Concise summary using five questions

The Handy Approach to Care

Safe, Quick, Person Centred

1. Thumb/**Cognition**: Is Jean able to remember what she did yesterday? *
2. Index finger/**Consent**: Does Jean give us permission to be involved in her care?
3. Middle finger /**Function**: Is Jean able to get out of bed?*
4. Ring finger /**Setting**: Is Jean alone at night or living with someone with impaired cognition?*
5. Little finger/**Hopes**: What matters to Jean when she is having a good day? What does Jean enjoy doing on a good day?

Handy Approach to Care Safeguarding Alerts

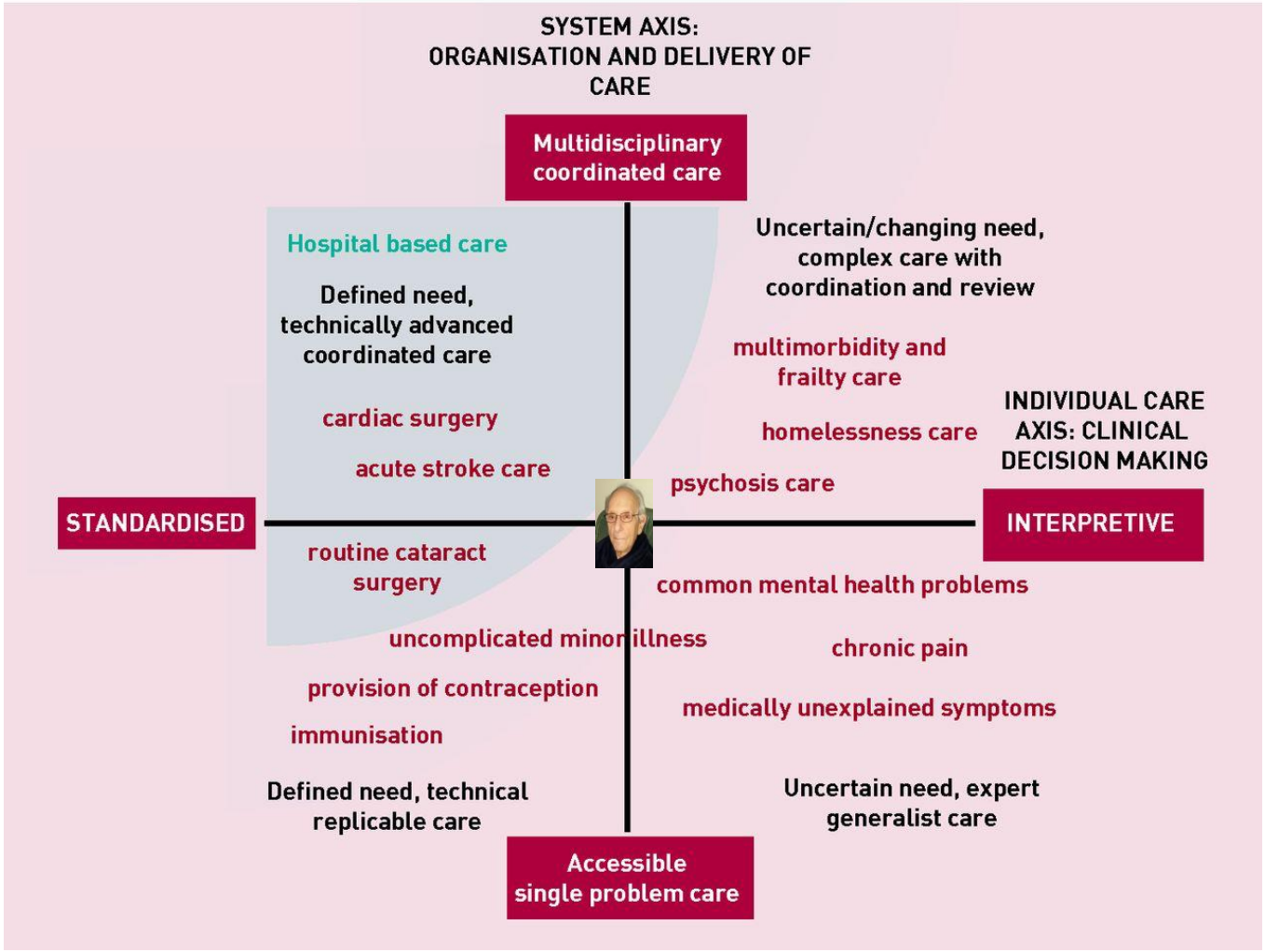
- Any cognitive impairment (cognition)
  - Acute e.g. delirium
  - Acute on chronic: e.g. delirium in a person with dementia
  - Chronic e.g. person with dementia
- Confined to bed/chair (function)
- Alone at night or lives with person with impaired cognition (setting)

If a person has all of the above, then then they will be vulnerable and will need resource intensive care

Resources Handy Approach to Care

- BMJ https://bmjopenquality.bmj.com/content/bmjqir/6/1/u214461.w5681.full.pdf
- Learning the Handy Approach to Care in time limited environments https://qi.elft.nhs.uk/wp-content/uploads/2018/06/Poster-A-HANDY-APPROACH-QUICK-WAYS-OF-LEARNING-IN-TIME-LIMITED-ENVIRONMENTS-_.pdf
- Flash learning on YouTube - 4minutes https://www.youtube.com/watch?v=-p8v6I-eFqg

Managing Uncertainty and Coproduction of Care



Realising the full potential of primary care:
uniting the 'two faces' of generalism. BJGP 2017
Joanne Reeve and Richard Byng

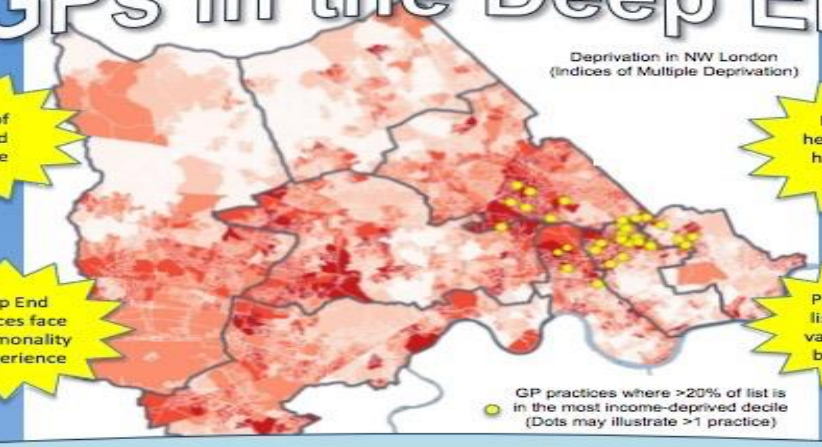
Working in the Deep End

GPs at the Deep End

NHS

H&F

GPs in the Deep End



Inequity of health and healthcare

Health and healthcare use have a social gradient

Deep End practices face a commonality of experience

Proportion of list in poverty varies 600-fold between GPs

Join a community of practices

The inverse care law means GP practices in deprived areas face unique challenges in regard to workforce and workload. These are hard to address working alone, but in other parts of the UK, GPs in deprived areas have boosted retention, recruitment and morale by forming a peer community based on shared values.

We've started a similar scheme, and are hosting a series of free, practical workshops to support community staff working with deprived communities in NW London:

July 9th:	**Understanding complexity**:	Why it's different in deprived areas
July 23rd:	**Growing up in poverty**:	The impact of adverse experiences
Aug 6th:	**Consultations**:	Empathy as a tool for behavior change
Sept 10th:	**Continuity**:	Strategies with a part-time workforce
Sept 19th:	**Mental health**:	Hope, agency and their impact on wellbeing
Oct 8th:	**Access to care**:	Perspectives of different community groups
Nov 5th:	**Self-care**:	Activation and the psychology of behavior change
Nov 19th:	**Living in poverty**:	Impact, resources and social assets

The Invention Rooms W12 7TA

Sessions run 12:30-15:00

Drop in to meet like-minded colleagues, hear the lectures and share experiences

For details contact: chockey@nhs.net

Important Contact Information

Share your concerns with

- Colleague in your practice
- Practice Safeguarding Lead
- Social care
  - London Borough of Hackney Adultprotection@hackney.gov.uk Tel 0208 356 578
  - City of London adultsduty@cityoflondon.gov.uk Tel 0207 332 1224
- C&H CCG Team
  - Mary O'Reardon – Designated Adult Safeguarding Lead Email: m.o'reardon@nhs.net Tel: 0208 208 3245
  - Liliana Risi – GP Clinical Lead Adult Safeguarding Email: LRISI@nhs.net

WWW/EBI

What went well?

Even better if…….